

National Practitioner Data Bank

The National Practitioner Data Bank was established by the Health Care Quality Improvement Act of 1986 and became operational September 1, 1990, as a flagging system to identify health care practitioners who may have been involved in incidents of medical incompetence. Reports of malpractice payments as well as licensure, clinical privileges, and professional society disciplinary actions (adverse actions) are fed into the Data Bank and made available on request to licensure and credentialing authorities.

Hospitals are required to query the Data Bank for new applications. They also are required to check the system every 2 years regarding all physicians, dentists, and other practitioners on their medical staff. Hospitals, as well as State licensing boards, health maintenance organizations, professional societies, and similar organizations may voluntarily query the Data Bank at any time.

Just Numbers or Knowledge?

JAMES S. TODD, MD

Dr. Todd is Executive Vice President of the American Medical Association.

Tearsheet requests to Dr. Todd, AMA, 515 North State St., Chicago, IL 60610; tel. 312-464-5000; FAX 312-464-5896.

IT IS DIFFICULT TO FIND anyone who is totally neutral or objective regarding the National Practitioner Data Bank (NPDB), and the article by Oshel and coworkers is a good example of why.

Their bias is obvious each time they equate a record in the Data Bank with incompetence, ignoring Section 427(d) of the Health Care Quality Improvement Act. This section states "that a payment made in settlement of a medical malpractice action or claim shall not be construed as a presumption that medical malpractice has occurred." The NPDB "Guidebook" (1) further states that "The information in the Data Bank should serve only to alert State licensing authorities and health care entities that there may be a problem with a particular practitioner's professional competence or conduct."

The authors' report includes extensive use of numbers, few of which are anything more than observed activity with no comment on the impact of these numbers. They highlight the 7.9-percent match rate of

queries during 1994, but fail to acknowledge the fact that only 2 percent of the matched reports made a difference in the hospital privileging decisions and only 3 percent made a difference in the decisions of managed care organizations. Consequently, only 0.09 percent of all queries affect a credentialing decision.

Although the Inspector General of the Department of Health and Human Services found that 83 percent of hospital officials consider the matched reports useful, the major reason was that the information only confirmed other reports that were available elsewhere. Furthermore, 45 percent of State licensing boards never queried the Data Bank, 78 percent of the boards believing they had better and less burdensome sources of information.

Much is made of the increased numbers of voluntary queries to the Data Bank, ignoring the fact that many of these are the result of managed care accreditation requirements, to say nothing of entities requiring physicians to self-query, thus avoiding the fee. Although the authors state that hospitals are supposed to query for their entire professional staff, the Health Care Quality Improvement Act only requires hospitals to query on practitioners who are on the *medical staff or hold privileges*.

Although Federal law expanded the Data Bank to include disciplinary actions on all licensed, certified, or registered health care practitioners, as yet that provision of the law has not been implemented, leav-

ing physicians and dentists under isolated scrutiny. In theory, the quality of the ancillary staff in the entity would have some bearing on liability or other actions sustained by physicians. And, in reality, there is little or no correlation between adverse action and medical malpractice payment reports.

The NPDB is having other unanticipated adverse effects. In 1993, the Physicians Insurers Association of America stated that 97 percent of their companies reported that physicians are less willing to settle claims as a result of the NPDB. Of malpractice reports, 21 percent of the payments were made for claims that were considered clearly defensible by the insurer, and presumably there are episodes of malpractice that never result in any action. Hospitals suspect a negative impact of the Data Bank on peer review actions. Also, 5 percent of hospitals report that the match reports were incomplete.

Although at the end of 1994 adverse actions represented 17.4 percent of the reports, slightly more than 6.6 percent of these were for modification of a previous adverse action report and actually were not adverse to the practitioner involved. Medical society reports are sparse mainly because adverse peer reviews occurring in facilities are already reported, and these societies have no influence over those who are not members.

Of perhaps greater significance is the \$9.9 million in query fees paid to the bank in 1994 to say nothing of the indirect costs of compiling and submitting queries. Given all of these concerns, one has to wonder what really is the value of the Data Bank?

Without question, the changes in America's health care system include the imperative for useful information on the quality and competence of practitioners and entities providing care. Despite great

attention to this imperative, no one yet has found an equitable, user-friendly, efficient manner for this documentation. The collection of massive amounts of data is seductive, but does it produce useful knowledge? Illustrative is the ill-fated attempt of the Health Care Financing Administration to disseminate hospital mortality rates as a measure of hospital quality. It was soon realized that such data were not useful or indicative, and the process was discontinued. The same may be said of the Data Bank as it now operates.

The authors make a strong case for the use of the Data Bank for research purposes, yet repeatedly they emphasize that the material must be interpreted with caution. It may be the bank does provide opportunities for research, but to date there is little evidence of useable knowledge being produced, and the recitation of numbers, while impressive, has not been very productive, nor is there any evidence that this is necessarily a unique data set. In an environment of cost constraint and the need for better measures of competence, it is difficult to justify the continuance of this expensive and seemingly flawed data repository.

Government's role should be to set the standards to which the profession should be held accountable, leaving it to the profession and those it serves to decide how close the practitioner or entity approaches those standards. There is a difference between data and knowledge. The National Practitioner Data Bank has yet to demonstrate that it can bridge that gap.

Reference

1. National Practitioner Data Bank guidebook. Public Health Service, Rockville, MD, October 1994.

Congress Should Open the National Practitioner Data Bank to All

SIDNEY M. WOLFE, MD

Dr. Wolfe is Director, Public Citizen Health Research Group, Washington, DC.

Tearsheet requests to Dr. Wolfe at 2000 P St., NW, Washington, DC 20036; tel. 202-833-3000; FAX 202-463-8842.

AS WE APPROACH the fifth anniversary of the operation of the National Practitioner Data Bank (NPDB), the main threat to this source of information about physicians is the desire of the American

Medical Association (AMA)—in the face of possible public access—to get rid of it.

At its meeting in the summer of 1993, the AMA House of Delegates passed a resolution stating, "Resolved, that the American Medical Association . . . call for the dissolution of the National Practitioner Data Bank."

Just as the AMA's implicit threat not to support the 1986 legislation that established the NPDB succeeded in getting specific language included forbidding disclosure of records to patients or